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ABSTRACT

Survey questionnaires concerning the response of rural schools to the Acquired Immune Deficiency Syndrome (AIDS) epidemic were sent to administrators of 400 randomly selected rural school districts in the United States. Of the 100 respondents, 80% provided some form of HIV/AIDS education. These programs varied greatly in goals, placement, length, and curricular content. A majority (56%) of schools with programs had involved their communities in program development, and 90% permitted parents to excuse their children from AIDS education. The most frequently named program goal was transmission of accurate AIDS information to students. Most programs were relatively brief, with 59% lasting 1 day or less and 40% lasting only 1-2 hours. A majority (60%) of schools included curricula concerning abstinence, condom use, safer sex, homosexuality, and sexually transmitted diseases. More AIDs education programs were provided in upper than lower grades, and most programs were part of health education classes. Only 34% of districts with programs had tools for evaluating them. Most schools had policies about attendance of HIV infected students, but most did not have policies about attendance of infected employees. For effective implementation, rural citizens, outreach agencies, social groups, and parents should be involved in designing and implementing sex education programs. This survey identified low levels of community and parent involvement in program planning. The survey questionnaire is included. (Author/SV)

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HIV/AIDS EDUCATION IN RURAL SCHOOLS IN THE U.S.: ENOUGH OF THE RIGHT STUFF?

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HIV/AIDS EDUCATION IN RURAL SCHOOLS IN THE U.S.: ENOUGH OF THE RIGHT STUFF?

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Abstract

Survey questionnaires concerning the response of rural schools to the HIV/AIDS epidemic were sent to 400 randomly selected rural schools in the U.S. A total of 100 schools returned usable surveys. Fully 80% of these schools provide some form of HIV/AIDS education program. These programs vary greatly in goals, placement, length, and curricular content. A majority (56%) of schools with programs involved their communities in the development of these programs, and 90% permit parents to excuse their children from HIV/AIDS education.

The most frequently named goals of these programs involve transmission of accurate HIV/AIDS information to students. A serious concern is the relative brevity of programs. Most programs are relatively short, with 59% lasting one day or less. Almost half (40%) are only 1-2 hours duration, and only one-fifth last 1/2-1 day.

A majority (60%) of schools include curricula concerning abstinence, condom use, safer sex, homosexuality and sexually transmissible diseases. More HIV/AIDS education programs are provided in upper than lower grades, and the majority of schools with programs include these within their health education classes. Another serious concern is that only 34% of the districts that responded to this survey that have HIV/AIDS education programs have tools for evaluating them.

Many schools also provide related programs. For example, 89% have substance abuse programs, and 54% have pregnancy prevention programs. Most schools have policies relating to the attendance of HIV infected students, but most do not have policies relating to the attendance of infected employees.

Research methodology would substantiate that a 25% rate of return on a national survey is a reasonable rate of return. At the same time, it is questionable whether the 75% who did not return the survey do not have HIV/AIDS programs and thus possibly have lower motivation to respond. Even of the 25% returning the survey, a significant minority (20%) do not provide HIV/AIDS education at all. Program brevity and evaluative processes are serious concerns regarding those with programs. Many rural schools do not offer health education, and many only provide 1-2 hours per week of any type of health education.

Two-thirds of all U.S. schools are rural, and 75% are small. This is a sizable constituency located primarily in traditional, conservative communities that are not usually enthusiastic about sex education. National studies have consistently indicated that successful sex education must be long term, integrated into ongoing curriculum, and holistic in nature (i.e., combined with self-esteem, decision making, assertiveness, and other training). In addition, for effective implementation, rural citizens, outreach agencies, social groups, and parents should be involved in program design and implementation. This survey identified an insufficient amount of involvement of the larger community, and especially parents, in planning programs.

HIV/AIDS Education in Rural Schools in the U.S.:
Enough of the Right Stuff?

Introduction

The AIDS epidemic began to appear in the early 1980's as an urban, gay men's health crisis. As time passed, urban intravenous drug users (IVDUs) and hemophiliacs were found to have high and increasing prevalence of the disease. It is not difficult to understand how AIDS has come to be viewed as a primarily urban phenomenon. Truly, the great majority of AIDS cases are diagnosed in urban centers (MacDonald, May 1989). Unfortunately, however, the perception that rural populations are somehow secure from the encroachment of the Human Immunodeficiency Virus (HIV) is both erroneous and perilous.

It is erroneous because AIDS has spread across the face of the nation. The U.S. Centers for Disease Control (April 1989) reports that cases of AIDS have been reported from all 50 states, 4 U.S. territories, and the District of Columbia. It is perilous because there seems to be a false security among rural populations; a belief that, as one rural interview respondent in the national study reported here stated, "It can't happen here" (Paulk, 1989). It can and it does occur across rural America.

Further, because most cases of AIDS exist among persons between the ages of 20 and 50, there is another misperception that AIDS is an adult disease; that it can't happen to teens. It is true that in the U.S. only 335, or 0.4% of people with AIDS (PWAs) are in the 13-19 year age group. However, it is essential to remember that the average time from HIV infection to AIDS diagnosis is estimated at 5 to 11 years. Thus, it is very likely that a substantial number of the 21% of PWAs who were diagnosed in their 20's (Washington State Office on HIV/AIDS, April 1989) were actually infected in their teens.

This is not meant to infer that rural, mainstream adolescents are necessarily at high risk for contracting HIV. The intent is rather to indicate that these young people do face a risk. Thus, rural schools bear a responsibility to take all appropriate measures to protect their youth from infection by this deadly virus. This means youth must be provided with medically accurate

information concerning routes of transmission of HIV, and with the knowledge and skills necessary to prevent infection.

While little research is available on what factors promote the efficacy of HIV education programs, a great deal of research has been conducted on pregnancy prevention programs. Since the knowledge, attitudes, and behaviors to be altered are quite similar in both kinds of programs, some applicable conclusions may be drawn from the latter body of research.

Jorgansen (1981) cites a formidable array of barriers to the effectiveness of pregnancy prevention education with teens. These include teens' own levels of cognitive development, traditional sex role perceptions, parental lack of involvement with educational efforts, and the negative effects of mass media on the sexual socialization of youth. In the face of these and other barriers, it is not surprising that most school pregnancy prevention programs have been shown to be, at best, minimally effective (Kirby, 1984; Zelnik and Kim, 1982).

Paulk (1985) found three factors which appear to facilitate the success of pregnancy prevention efforts. First, the program should be long enough to effect significant, lasting change. Second, the program should be comprehensive, dealing with as many as possible of the varied issues surrounding pregnancy prevention and sexual risk taking. These issues include sexual and contraceptive knowledge, self-esteem, decision-making skills, and assertiveness skills. Finally, the program should involve students, both intellectually and emotionally, in the learning process.

To the degree to which these findings are generalizable to HIV prevention, we may conclude that (1) significantly impacting sexual risk-taking behavior is difficult, and (2) designing and implementing effective programs requires commitment and creativity. This paper provides a look at what rural schools are currently doing to meet the challenge of preparing their students to avoid HIV.

Method

In 1988, the National Rural and Small Schools Consortium (NRSSC), under a grant from the Centers for Disease Control (CDC), sent questionnaires to the district administrators of 400 rural school districts across the U.S. These schools were randomly selected from a mailing list of

rural school districts, defining a "rural" school district as a school district located in a community with fewer than 150 inhabitants per square mile, or in a county in which at least 60% of the population resides in a community with no more than 5,000 inhabitants (Helge, 1981). The purpose of the survey was to gather baseline data on the number of rural schools providing HIV/AIDS education to their students; age and grade levels to which this education was presented; proportion of programs which were mandated by legislative action; goals of existing curricula and programs; and procedures used in evaluating outcomes of these programs.

Of the 400 school districts randomly receiving questionnaires, 100, or 25%, completed and returned these to NRSSC. Five other schools (1.25%) returned questionnaires that were too incomplete to be considered. Responses to objective (yes/no or multiple choice) survey items were tallied and converted into percentages. Responses to subjective items (items requiring respondent-generated answers) were categorized, then tallied and converted into percentages.

Of the schools which responded, 7% included kindergarten, a mean of 75% (range 74-77%) included grades 1-6, 80.5% (range 79-82%) included grades 7-8, and 68.3% (range 67-69%) included grades 9-12. Collectively, the schools served 66,733 students, with a mean student population of 725.

Availability of HIV/AIDS Education in Rural Schools

An encouraging 80% of schools surveyed provide some form of HIV/AIDS education program. However, 19% do not, and 1% did not answer this item. In all, a reported 34,234* students, or 51% of the total number served by the schools in this sample, received some form of HIV/AIDS education during school year 1988-89.

Most (72%) of all schools, or 90% of schools with programs, permit parents to have their children excused from HIV/AIDS education if they wish. Almost half (45%) of all schools, or 56% of schools with programs, involved parents, students, and/or community representatives in the development of their programs. Half of all schools reported that HIV/AIDS education is mandated by their state's legislature.

* The usefulness of this figure is limited by the fact that only 75 schools responded to this particular item.

Program Goals

Respondents were asked to subjectively list the goals of their schools' HIV/AIDS education programs. A total of 22 categories of goals emerged. In this section, these goals will be described in order of frequency of mention. For purpose of clarity, frequency figures will be given as percentages of the 80 schools with existing programs.

The most frequently mentioned goal, listed by 16% of schools with programs, is to provide current information about AIDS and related diseases. The second most frequently named goal is to explain how the AIDS virus is transmitted, and was listed by 15% of schools. Next, with 13%, is to promote skills for prevention of HIV transmission. Ten percent of schools want to increase their students' general knowledge about AIDS.

The following three goals each were mentioned by 9% of schools. They are: to promote abstinence; to provide supplementary forms of AIDS education to students and/or community; and to instill a high level of awareness of AIDS issues. To teach about high risk behaviors, to prevent the spread of HIV/AIDS, and to define what AIDS is were each named as goals by 6% of schools. Receiving mention by 5% of schools were to show that AIDS is a serious problem, to dispel myths about AIDS, and to teach safer sex.

The following five goals were each listed by 4% of schools: to increase students' knowledge of sexually transmitted diseases (STDs); to discuss students' fears about AIDS; to improve the self-esteem of students; to improve students' quality of life; and to encourage development of personal values as a means of AIDS prevention.

Four goals were each listed by 3% of schools with programs. These are: to teach how AIDS is not transmitted; to help students avoid contracting HIV; to reduce risks; and to develop empathy toward people with AIDS. Finally, the following goals were mentioned by one school each: to review HIV education yearly; to teach methods of virus identification; to teach legal implications of AIDS; and to develop goals.

Of the 22 goals named by at least 3% of the schools, 9 rated primarily to knowledge acquisition, 8 to acquisition of positive skills and behaviors, and 5 to development of positive

attitudes and values. Indeed, attention to improvement in each of these three areas is essential to a comprehensive, effective HIV/AIDS education program. The next section discusses the length and content of programs, in light of these goals.

Length of Programs

Only 38% of all schools in this sample report program offerings running one week or longer, compared with 40% which offer programs of 1-2 hours duration. One-fifth say they offer some programs lasting one-half to one full day. Many schools offer programs of different durations in different grades. The 80 schools with programs offer a total of 176* HIV/AIDS education programs to some or all of their separate grades.

A total of 72 (41%) of these programs are offered at the high school (9-12) level; 47, or 27%, are at the junior high (6-8) level; and 57, or 32%, are at the elementary (K-6) level. Figure 1 (page 13) shows the distribution of program offerings of different durations, with grade levels combined into elementary, junior high schools, whereas at the elementary level programs tend to be considerably or high, and high school. Percentages are calculated based on 100% of the programs in that grade level. As the figure indicates, long-term programs are somewhat more likely to be offered at the junior high and high schools, whereas at the elementary level programs tend to be considerably shorter.

Content of Programs

Schools were asked to report whether they include abstinence, condoms, safer sex, STDs, and homosexuality in their HIV/AIDS program, and to list any other topics they include in their program. The majority (72%) of all schools include abstinence, 55% include condoms, 54% include safer sex, 53% include homosexuality, and 74% include STDs in their program. Almost half of all schools, or 60% of schools with programs, include all 5 topics. In addition, each of the following are topics included by two schools: communicable diseases; disease in general; drug education; and presentation of HIV education as part of a regular course. Social issues was listed as a topic included by one school.

* The figure 176 was derived by calculating the total number of grades in which HIV/AIDS instruction is provided in some form.

Fully 67% of schools report that their HIV/AIDS education programs describe specific behaviors that increase the risk of HIV infection. Almost two-thirds report that their programs describe abstinence from sexual activity and intravenous drug use as the only sure ways to avoid HIV infection. A lower, but still sizable, 42% report that their programs describe the effectiveness of condom use in decreasing HIV risk.

Placement of Programs

Schools were asked to give information regarding the placement and availability of HIV/AIDS education within their overall curriculum. HIV/AIDS education programs are most frequently presented in the 7th and 8th grades. Most of these (59% and 60%, respectively) report that they offer programs in these grades. Many schools offer programs in several grades. Figure 2 (page 14) shows the proportion of schools offering HIV/AIDS education programs by grade level. As is indicated in the figure, the percent of schools offering programs rises dramatically in the 5th grade, continuing through the 12th.

Almost half (45%) of schools report that HIV/AIDS education has been implemented as part of a more comprehensive school health education program. A total of 46% present their program as part of a unit on sexually transmitted diseases. Over two-thirds of schools report that they provide at least some of their instruction within regular Health Education classes. Over one-fifth report providing instruction in their Biology or Science classes, and 14% provide instruction within their Human Sexuality classes. One-third of schools hold special assemblies or other programs for the presentation of HIV/AIDS education programs. A small minority (6%) of schools offer programs in their Home Economics classes, 3% in Physical Education classes, 2% in special classes specifically on HIV/AIDS, and 2% on field trips. One school (1%) presents the program in a Communicable Diseases class.

Most schools (72%) say their program is being taught by health education teachers. One school (1%) has the school nurse present the information to each grade level. In addition, 59% of schools do provide HIV/AIDS education to their special education students. Only 10% provide instruction in languages other than English, where appropriate.

Evaluation of Programs

At the time this survey was conducted, only 27% of schools in the sample had developed a system to monitor and periodically assess the quality of HIV/AIDS education programs. Put another way, 66% of schools with programs do not have instruments available to measure the extent to which these programs are effective at attaining their specified goals.

It is admittedly difficult or impossible to measure some aspects of program effectiveness. For example, we can never know how many cases of HIV infection have been prevented by a given program. On the other hand, goals involving knowledge acquisition and retention, attitudinal change, and short term reported behavior change are fairly easily measured.

Related Programs

Schools were requested to provide information on any non-HIV related, risk reduction programs they offered. Almost all (89%) of schools present substance abuse prevention programs. Over half (54%) offer programs intended to reduce the risk of teen pregnancy. Almost half (44%) of schools offer suicide prevention programs, and 30% have dropout prevention programs. Over one-fourth (28%) have other risk prevention programs in place, including health education (9% listed) and counseling programs (4% listed).

Another 5% said they would like to have alcohol/substance abuse programs in their schools, and 13% stated a desire to offer pregnancy prevention programs. Suicide prevention and dropout prevention were each named by 16% of schools as desired programs. A small minority (9%) said they would like to offer other risk reduction programs, including self-esteem, decision making, and goal setting (2%), and improving family relationships (1% each).

Asked which programs they would like assistance with, 29% listed teen pregnancy. Alcohol/substance abuse prevention and suicide prevention were each listed by 23% of schools. One-fifth (21%) listed dropout prevention as an issue they would like help with. A total of 17% listed other risk related topics, including other aspects of HIV/AIDS (2%), peer counseling and parenting programs (1% each).

Special Policy Issues

The majority (55%) of schools surveyed stated that they have a policy on attendance of employees diagnosed as having AIDS or being infected with HIV. However, 39% do not have such a policy, and 6% did not respond to this item on the questionnaire.

A majority of schools (52%) *do not* have a policy on attendance of employees diagnosed as having AIDS or being infected with HIV. Almost half (41%) of schools do have such a policy, and 7% did not answer this item. Over half (56%) of all schools surveyed report that their administrators, counselors, and/or nurses have received special training or workshops about HIV/AIDS.

Conclusion

The large majority of rural schools in the U.S. offer some form of HIV/AIDS education to their students. The goals, placement, length, and curricular content of these programs vary a great deal, yet several common themes seem to run through many of them. These themes include the provision of accurate information on HIV/AIDS, development of a realistic perspective toward the epidemic, and development of skills for prevention of HIV transmission to their students. A slight majority of schools with programs provide instruction on a comprehensive range of HIV-related issues, and a similar majority involved the larger community, in some form, in the process of planning their programs.

Problems include the relative brevity of most programs, and lack of instruments for evaluation of program effectiveness in most schools. In addition, a significant minority of schools in this sample either do not provide HIV/AIDS education at all, do not provide comprehensive educational programs, and/or do not involve the larger community, and parents in particular, in the planning of these programs.

Clearly, much good work is being done by many of America's rural schools. Just as clearly, given the disposition to risk taking by adolescents and the increasing geographic pervasiveness of this deadly epidemic, much more remains to be done.

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FIGURE 1:

Percent of Programs Offered
in Each Grade Level by Duration

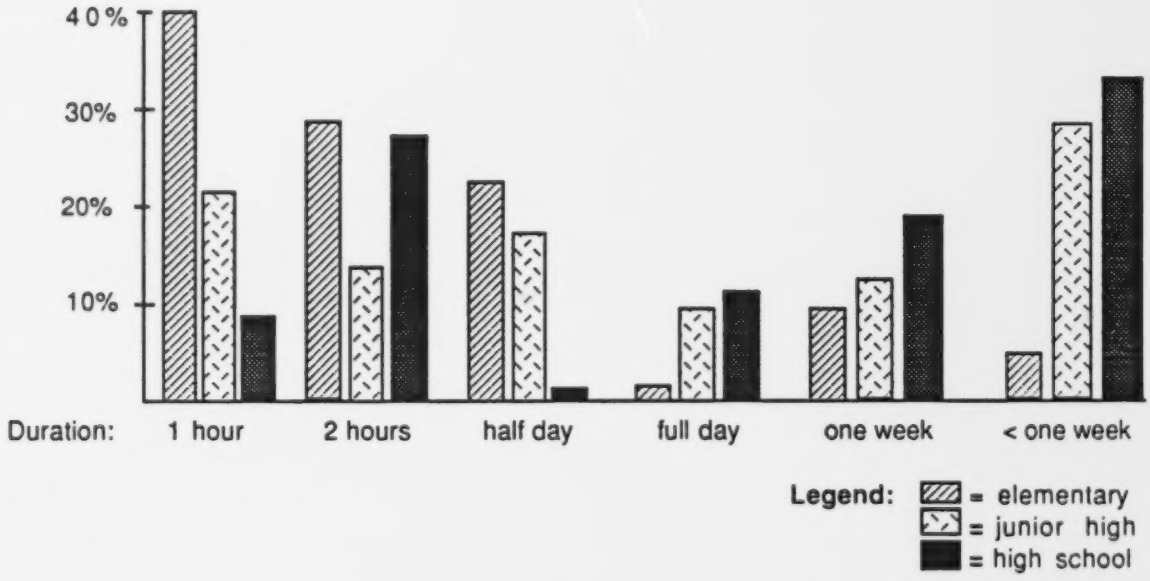
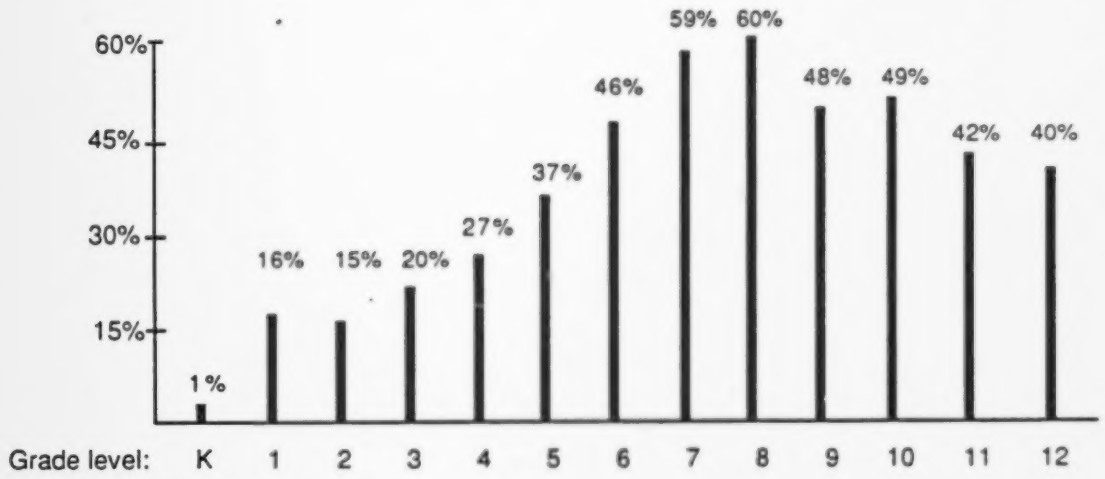


FIGURE 2:

Percent of Schools with HIV/AIDS Programs by Grade Level (K-12)



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NATIONAL RURAL AND SMALL SCHOOLS CONSORTIUM (NRSSC)

AIDS Education in Rural Schools Program
Questionnaire

Name: _____

Position: _____

Institution: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

A. Check the grade levels in your school.

☐ 1st ☐ 4th ☐ 7th ☐ 10th
☐ 2nd ☐ 5th ☐ 8th ☐ 11th
☐ 3rd ☐ 6th ☐ 9th ☐ 12th

B. How many students are enrolled in your school during the 1988/1989 school year? _____

C. Do you provide AIDS education in your school district? ☐ Yes ☐ No

If yes, please answer the following:

1. Is it mandated by your state legislature? ☐ Yes ☐ No

2. May parents request that their child be excused from AIDS education? ☐ Yes ☐ No

3. In what grades is AIDS education provided?

☐ 1st ☐ 4th ☐ 7th ☐ 10th
☐ 2nd ☐ 5th ☐ 8th ☐ 11th
☐ 3rd ☐ 6th ☐ 9th ☐ 12th

4. What is the length of the instruction? (note which grades in blank spaces)

☐ One hour _____ ☐ Two hours _____
☐ Half day _____ ☐ Full day _____
☐ One week _____ ☐ More than a week _____

5. Which of the following topics are included in the instruction? (note which grades in blank spaces)

☐ Abstinence _____ ☐ Safer sex _____
☐ Condoms _____ ☐ Sexually transmitted
☐ Homosexuality _____ diseases _____

Other (please list): _____

6. How many students will receive AIDS education in your school between September 1988 and June 1989? _____

7. Where is AIDS education provided (check all that apply)? ☐ Health education classes ☐ Human Sexuality classes ☐ Biology or science classes ☐ Assemblies or special programs

☐ Other (please explain): _____

D. Does your school or district have a policy on attendance of students diagnosed as having AIDS or being infected with the AIDS virus? (if yes, please attach a copy of the policy) ☐ Yes ☐ No

E. Does your school or district have a policy on attendance of employees diagnosed as having AIDS or being infected with the AIDS virus? (if yes, please attach a copy of the policy) ☐ Yes ☐ No

F. Check each of the following criteria that applies to your school's AIDS education program.

☐ Parents, students, and/or other appropriate community representatives were involved in developing the AIDS education program.

☐ The AIDS education program has been implemented as part of a more comprehensive school health education program.

☐ The AIDS education program is being taught as part of an STD (sexually transmitted disease) unit.

☐ The AIDS education program is being taught by health education teachers or other similiar qualified personnel.

☐ The AIDS education program describes abstinence from IV drug use and sexual activity as the only sure ways to avoid HIV infection.

☐ The AIDS education program describes the effectiveness of condoms in decreasing the risk of HIV infection among sexually active adolescents.

☐ The AIDS education program describes specific behaviors that increase the risk of being infected with the AIDS virus.

☐ School administrators, nurses, and/or counselors have received special training or workshops about AIDS.

☐ A system has been developed to monitor and periodically assess the quality of the AIDS education program.

☐ AIDS education is provided to special education students.

☐ AIDS education is available in non-English languages when appropriate.

G. List the goals of your AIDS education program. _____

_____

_____

_____

_____

_____

_____

_____

H. Do you provide educational programs regarding:

- ☐ Alcohol and substance abuse
- ☐ Dropout prevention
- ☐ Teenage pregnancy
- ☐ Teenage suicide
- ☐ Suicide prevention
- ☐ Other at-risk student situations

If so, please describe: _____

_____

I. What programs that you do not now have would you like to have in your district?

- ☐ Alcohol and substance abuse
- ☐ Dropout prevention
- ☐ Teenage pregnancy
- ☐ Teenage suicide
- ☐ Suicide prevention
- ☐ Other at-risk student situations

If so, please describe: _____

_____

J. What programs would you like assistance with (e.g., materials, inservice training, etc.)?

- ☐ Alcohol and substance abuse
- ☐ Dropout prevention
- ☐ Teenage pregnancy
- ☐ Teenage suicide
- ☐ Suicide Prevention
- ☐ Other at-risk student situations

If so, please describe: _____

_____

* Please note that we would appreciate a copy of any instruments you use to measure the results of your AIDS education curricula.

* Please attach a copy of all materials related to AIDS education used by teachers or students in your school.

Return to:

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